

**MSP SCRIPT – To inform member of being transitioned and to verify information:**

Hello, may I speak with Mr.(Ms.) Name.

Hello, Mr. (Mrs.) Name. I am calling from [Sponsor's name] on behalf of Medicare. Our Medicare records show that you very likely qualify for a \$600 credit in 2004 and another \$600 credit in 2005. You can use this \$1200 credit to help pay for your prescriptions this year and next.

We recently mailed you an Important Message from Medicare and a package containing a Medicare-approved drug discount card.

Did you receive the package and the card?

If YES:

Your new membership card will allow you to receive discounts on your prescriptions. The card will be effective November 1, 2004. Since [name of State] helps pay your Medicare premiums or deductibles, you are likely to also qualify for up to \$1,200 in credits to use for your prescription drug costs.

In order to make sure that you do qualify for the \$1200 I will need to ask you a few questions including: income, date of birth and the last four digits of your social security number.

**CSR Note:** The person with Medicare must be present to give consent and information. Additionally, if the person did not receive the packet confirm the address and send out another packet.

Please confirm your full name, address and the last four digits of your social security number.

Are you married?

Is your current monthly income above or below \$xxxxxx

Does your income include your spouse's income?

Do you have prescription drug coverage through an employer, TRICARE etc.?

If YES:

Because you have other drug coverage you do not qualify for the \$600 credit. However, you can still use the Medicare approved prescription drug card and get savings on your drugs. If you chose to use the card you will have to pay an enrollment fee of [xx.xx].

**CSR Note: If the beneficiary does want to enroll in the card, provide the person with the 1-800 Medicare number for information on other programs**

If NO:

You will qualify for \$1,200 credit toward the cost of your prescription drugs purchased through the [name of the drug card] and Medicare will pay the enrollment fee. You will pay a small coinsurance amount for each prescription. The amount of coinsurance you will pay depends on your income, if your monthly income is above xxx you will pay 10% and if your monthly income is below xxx you will pay 5% for your prescription drugs.

Thank you .

That is all the information that I will need. Your \$1200 credits will be activated on the 1<sup>st</sup> day of the following month based on the information you have provided. You will receive written confirmation if you are not approved. You may also follow up with our customer service department to confirm when you may begin using the credit.

**CSR Note:** It is possible that residents of LTC facilities and those who use an Indian Health Service, Tribal or Urban Indian pharmacy may not have gotten a card in the mail that would allow them to get discounts on their prescription drugs at these specialty pharmacies. Refer these individuals to 1-800 Medicare if they would like to choose another card that would work in these pharmacies.

If you have any further questions about your enrollment, including whether the medications you take are covered, or if you want to cancel your membership, please call the Customer Service department at [insert toll-free number]. You can speak to someone at this number [insert days and hours of operation].

Or, if you have general questions about the Medicare-approved discount drug cards, call 1-800-MEDICARE (1-800-633-4227)

Do you have any questions at this time?

If NO:

Thank you for your time. Please feel free to contact us at [insert sponsor's toll free number] if you have any questions in the future.